CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 479	**Date: August 1, 2013**
	Change Request 8039

Transmittal 469, dated May 31, 2013, is being rescinded and replaced by Transmittal 479, dated August 1, 2013, to revise the Manual Instructions and Business Requirements 8039.7.1, 8039.8.2, 8039.10.1, 8039.11.3, 8039.15.1, and 8039.17 to make clarifying and technical policy edits based on industry concerns. All other information remains the same.

SUBJECT: Enrollment Denials When an Existing or Delinquent Overpayment Exists

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to revise section 15.13 of Pub. 100-08, Program Integrity Manual, Chapter 15 for provider enrollment. This new section shall offer guidance on denying newly enrolling or change of ownership applications when an existing or delinquent overpayment exists for an owner of a current provider or supplier or for a physician or non-physician.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/15.13/Delinquent Overpayments
N	15/15.24.8.6/Denial Example #6 – Delinquent Overpayments

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding or implementation activities will be provided to contractors through the regular budget process.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 479	Date: August 1, 2013	Change Request: 8039

Transmittal 469, dated May 31, 2013, is being rescinded and replaced by Transmittal 479, dated August 1, 2013, to revise the Manual Instructions and Business Requirements 8039.7.1, 8039.8.2, 8039.10.1, 8039.11.3, 8039.15.1, and 8039.17 to make clarifying and technical policy edits based on industry concerns. All other information remains the same.

SUBJECT: Enrollment Denials When an Existing or Delinquent Overpayment Exists

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

I. GENERAL INFORMATION

A. Background: Under 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502 - *Owner* means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act) of the applying provider or supplier, or (2) the applying physician or non-physician practitioner, has an existing overpayment that has not been repaid in full at the time the application was filed. Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States (US) Government or US Treasury.

B. Policy: Consistent with §424.530(a)(6) and the instructions in this change request, the contractor may deny a Form CMS-855 application if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing overpayment that has not been repaid in full at the time an application is filed.

NOTE: First, contractors shall not deny any application pursuant to this Transmittal without receiving approval to do so from CMS' Provider Enrollment Operations Group. Second, this Transmittal does not apply to overpayments that are part of a repayment plan or are currently being offset or appealed.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8039.1	Contractors shall generate a daily listing that identifies all organizations, physicians and/or non-physician practitioners with an existing or delinquent overpayment equal to or greater than a threshold of $1500. The $1500 threshold shall include the principal overpayment amount and the accrued interest amount.	X	X	X	X	X	X	X					NSC
8039.1.1	Contractors shall be expected to generate the listing referenced in BR 8039.1 from the Receivables Balance Details Report (RBD) in HIGLAS.	X	X	X		X	X	X					
8039.1.2	The NSC shall receive this listing referenced in BR 8039.1 from VMS.												NSC
8039.1.3	The listing shall consist of the following information: contractor name, contractor ID, legal business name or legal name of the provider or physician\non-physician practitioner, National Provider Identifier, Original 2-position Reason/Discovery Code, description associated with original 1-position Reason Code, description associated with original 1-position Discovery Code, cumulative principal overpayment amount, the accrued interest amount and the total cumulative (including accrued interest) amount of the existing or delinquent overpayment equal to or greater than a threshold of $1500 applicable for each organization or each physician or non-physician practitioner. The $1500 threshold shall include the principal overpayment amount and the accrued interest amount.										X		HIGLAS
8039.2	HIGLAS shall make the following parameters available on the Receivables Balance Details Report (RBD) in HIGLAS: 1. contractor name, 2. description associated with the original Reason code –in Part A												HIGLAS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	(MAC) this is a 2-position code which translates to the overpayment type in HIGLAS (i.e., AA, CA, DA), 3. description associated with the original 1-position Discovery code -in Part B (MAC) this is a 1-position code which translates to the overpayment type in HIGLAS (i.e., F, G, C).												
8039.2.1	If there is no data to report on overpayment information from HIGLAS, the report shall provide a standard message of "no data found" for the contractors to use.	X	X	X		X	X	X					
8039.3	Contractors shall be responsible for accessing the Receivables Balance Details Report (RBD) in HIGLAS and running the report to capture the data elements found in 8039.1.3.	X	X	X		X	X	X					
8039.3.1	Contractors shall have the ability to generate the report in both a summary and detail. The RBD report is convertible to an Excel format.	X	X	X		X	X	X					
8039.4	HIGLAS shall ensure overpayment information is accessible by the enrollment staff at each Part A/B MACs and legacy contractors.	X	X	X			X	X					HIGLAS
8039.4.1	A request for access shall be made by management for the enrollment staff to have inquiry only access to the HIGLAS reporting system. Inquiry access only will allow the enrollment staff to run the report. This is due to there being a limited number of licenses for HIGLAS use at each MAC.	X	X	X		X	X	X					
8039.5	VMS shall create a system generated daily report as described in BR 8039.1. for use by the DME MACs.				X						X		NSC
8039.5.1	VMS shall create a daily flat file based on the data described in BRs 8039.1.3. The format and content of the flat file shall be determined between the VMS and NSC contractors.										X		NSC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8039.5.2	VMS shall ensure an updated 2 position Reason/Discovery Code is added to the data listing on the report referenced in 8039.1.3.										X		
8039.5.3	The EDC shall transfer the overpayment listing flat file created by VMS containing the data as described in BR 8039.2.1 to the provider enrollment department at the NSC MAC on a daily basis.												EDCs, NSC
8039.6	Contractors shall determine upon application review (i.e. contractor is pre-screening or processing the application) of either Form CMS-855A, 855B, or 855S, initial or change of ownership application and by reviewing the existing or delinquent overpayment file, if an 855 application shall be denied.	X	X	X		X	X	X					NSC
8039.7	Contractors shall be responsible for conducting a search for individuals or organizations who are owners of entities enrolled in PECOS.	X	X	X		X	X	X					NSC
8039.7.1	Contractors shall verify the owner of such entity (based on the ownership information available in PECOS) to identify if a denial is warranted. Contractors shall utilize the updated search features in PECOS to detect any organization that has an existing or delinquent overpayment.	X	X	X		X	X	X					NSC
8039.7.2	This search function shall include all entities along with NPIs for each entity listed. An exportable mechanism via Excel is available through PECOS for this list.	X	X	X		X	X	X					NSC
8039.8	Contractors shall review the overpayment file a 2nd time prior to making a final determination to recommend a CMS 855A for approval or denial for initial or change of ownership application.	X		X		X		X					
8039.8.1	Contractors shall conduct this final review of the overpayment file to ensure the overpayment status has not changed.	X		X		X		X					
8039.8.2	If the determination is to deny the application,	X		X		X		X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	contractors shall forward the request to their Business Function Lead (BFL) for further instruction prior to proceeding.												
8039.9	Contractors shall review the overpayment file a 2nd time prior to making a final determination to approve or deny an initial or change of ownership for a CMS 855B or CMS 855S application.		X										NSC
8039.10	Contractors shall conduct this final review of the overpayment file to ensure the overpayment status has not changed.		X										NSC
8039.10.1	If the determination is to deny, contractors shall forward the request to their Business Function Lead (BFL) for further instruction prior to proceeding.		X										NSC
8039.11	Contractors shall determine upon receipt (i.e. contractor is screening or processing the application) of an initial Form CMS-855I application, and by reviewing the existing or delinquent overpayment file, for a physician or non-physician practitioner has an existing or delinquent Medicare overpayment and if the 855I application shall be denied.		X										
8039.11.1	For purposes of this requirement, the term “non-physician practitioner” shall include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals		X										
8039.11.2	Contractors shall review the overpayment file a 2nd time prior to making a final determination to approve or deny an initial or change of ownership for a CMS 855I application. Contractors shall conduct this final review of the overpayment file to ensure the overpayment status has not changed.		X										
8039.11.3	If the determination is to deny, contractors shall forward the request to their Business Function Lead (BFL) for further instruction prior to proceeding.		X										

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8039.12	Using the daily overpayment list in BR 8039.1, the NSC MAC shall verify that that each initial enrollment application or an application that establishes a new owner does not have an existing or delinquent overpayment.												NSC
8039.13	The NSC MAC shall not approve any initial enrollment or change of ownership application without first verifying the existing overpayment listing.												NSC
8039.14	Contractors shall refer to the instructions in section 15.13 to determine whether an overpayment exists.	X	X	X		X	X	X					NSC
8039.15	Contractors shall deny the application, using 42 CFR §424.530(a)(6) as the basis, if an owner, physician, or non-physician practitioner has such an overpayment.	X	X	X		X	X	X					NSC
8039.15.1	Contractors shall exclude from denial: 1. Individuals or entities on a Medicare-approved plan of repayment or payments are currently being offset: 2. Overpayments that are currently being appealed	X	X	X		X	X	X					NSC
8039.15.2	Contractors shall not issue a denial if the only exception to BR 8039.16.1 is if the reason for the overpayment is due to contractor or system error or the provider is bankrupt.	X	X	X		X	X	X					NSC
8039.16	Contractors shall not deny an application if the overpayment has been paid in full.	X	X	X		X	X	X					NSC
8039.17	Contractors shall deny the application in PECOS using the Denial status with reason of 'Existing Overpayment'.	X	X	X		X	X	X					NSC, PECOS
8039.18	Contractors shall only review its own records to see if an overpayment exists.	X	X	X		X	X	X					NSC
8039.18.1	Unless CMS instructs otherwise, contractors	X	X	X		X	X	X					NSC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	shall not contact other contractors to determine whether the person or entity has an overpayment in other contractor jurisdictions.												
8039.19	Contractors shall determine whether the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 15.13.	X	X	X		X	X	X					NSC
8039.20	Contractors shall not deny the application as described in section 15.13 if the overpayment is not equal to or does not exceed a $1500 threshold.	X	X	X		X	X	X					NSC
8039.21	The contractor shall include the total overpayment amount in any denial letter.	X	X	X		X	X	X					NSC
8039.22	Contractors shall include appeal language in accordance with IOM, Pub. 100-08, Chapter 15, section 25 – Appeals Process in all denial letters to provider.	X	X	X		X	X	X					NSC
8039.23	Contractors shall e-mail the Denied CMS 855 Application Report due to an existing or delinquent overpayment described in BR 8039.1 to the Provider Enrollment Operations Group (PEOG) at CMS along with its Contracting Officer Representative (COR) in Excel format by the 10th calendar day of each month.	X	X	X		X	X	X					NSC
8039.23.1	The report from the contractors shall only contain the CMS 855 applications that have been denied due to an existing or delinquent overpayment. CMS is not asking contractors to report to PEOG providers who have an existing or delinquent overpayment neither if an overpayment has been resolved.	X	X	X		X	X	X					NSC
8039.24	Contractors shall include an explanation on the monthly report to PEOG for any overpayments issued in error where the application is not denied.	X	X	X		X	X	X					NSC
8039.25	Contractors shall submit the enrollment denial report to CMS even if there is no denial	X	X	X		X	X	X					NSC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	action to report. The report shall indicate - "No denials to report."												
8039.26	The Rail Road Board (RRB) shall be exempt from these requirements since they do not process CMS 855 Medicare enrollment applications.												RRB

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8039.27	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X		X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Alisha Banks, 410-786-0671 or alisha.banks@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
Funding or implementation activities will be provided to contractors through the regular budget process.

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENT (1)

Medicare Program Integrity Manual

Chapter 15 - Medicare Enrollment

Table of Contents

(Rev.479,Issued: 08-01-13, Effective:10-01-13,Implementation: 10-07-13)

15.13 – *Existing or Delinquent Overpayments*

(Rev.479, Issued: 08-01-13, Effective: 10-01-13, Implementation: 10-07-13)

Consistent with 42 CFR §424.530(a)(6), an enrollment application may be denied if: (1) the current owner (as that term is defined in 42 CFR §424.502) of the applying provider or supplier, or (2) the applying physician or non-physician practitioner, has an existing overpayment that is equal to or exceeds a threshold of $1500 and it has not been repaid in full at the time the application was filed. To this end, the contractor shall:

- *When processing a Form CMS-855A, CMS-855B, or 855S initial or change of ownership application, determine – using a system generated daily listing - whether any of the owners listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment.*

- *When processing a Form CMS-855I initial application, determine – using a system generated daily listing - whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term "non-physician practitioner" includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.)*

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR §424.530(a)(6) as the basis. However, prior approval from the Provider Enrollment Operations Group (PEOG) is required before proceeding with the denial. The contractor shall under no circumstances deny an application under §424.530(a)(6) without receiving PEOG approval to do so.

Consider the *following examples:*

Example #1: Hospital X has a $200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the $50,000 overpayment was attached to him as the sole proprietor.

Example #3 - Same scenario as example #2, but assume that his new practice is an LLC of which he is only a 30 percent owner. A denial is not warranted because the provision applies to owners and, again, the $50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

***NOTE:** The contractors shall also observe the following:*

- *In determining whether an overpayment exists, the contractor need only review its own records; it need not contact other contractors to determine whether the person or entity has an overpayment in those contractor jurisdictions.*

- *The instructions in this section 15.8.4 apply only to (1) initial enrollments, and (2) new owners in a change of ownership.*

The term "owner" under section §424.502 means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act)

- *If the person or entity had an overpayment at the time the application was filed but repaid it in full by the time the contractor performed the review described in this section 15.8.4, the contractor shall not deny the application based on 42 CFR §424.530(a)(6).*

15.24.8.6 –Denial Example #6 – Existing or Delinquent Overpayments
(Rev.479, Issued: 08-01-13, Effective: 10-01-13, Implementation: 10-07-13)

MEDICARE ADMINISTRATIVE CONTRACTOR INC.
1234 MAIN STREET
ANYTOWN IL 12345
"Excellence in Health Care Services"

June 5, 2012

Xantippe Jones, LMFT
7824 Freudian Way
Yakima, WA 94054

Dear Mr. Jones:

Your application to enroll in Medicare is denied for the following reason(s):

Denial Reason 6 (42 CFR §424.530(a)(6))

The current owner (as defined in §424.502), physician or non-physician practitioner has an existing overpayment at the time of filing an enrollment application.

Dates (entered date of existing or delinquent overpayment period)

Pertinent details of action(s) (Whether the person or entity is on a Medicare-approved plan of repayment or payments are currently being offset: Whether the overpayment is currently being appealed; the reason for the overpayment.

If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements. The reconsideration request must be signed by the authorized or delegated official within the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group
Mailstop Code (AR-18-50)
7500 Security Boulevard
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The reconsideration must state the issues or findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration that you believe may have a bearing on the decision. The reconsideration must be signed and dated by the authorized or delegated official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

The reconsideration request should be sent to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group
Mailstop Code (AR-18-50)
7500 Security Boulevard
Baltimore, MD 21244-1850

If you have any questions, please contact our office at 601-555-1234 between the hours of 9:00 AM and 5:00 PM.

Sincerely,

Crispin Bacon
Provider Enrollment Analyst
Medicare Administrative Contractor, Inc.

A CMS Medicare Administrative Contractor

Contractor ID	Contractor Name	Application Type Submitted (855A/B/I/S)	Legal Business Name of Provider of Applicant	TIN

Legal Name	SSN#	NPI	Principal Overpayment Amount	Interest Accured	Total Overpayment Amount	Bankrupt Provider (Y/N)

Application Status (Denied - Y/N)	Contractor Comments (if applicable)